STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
300 W. Preston Street, Suite 202, Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Office of Preparedness & Response
Sherry Adams, Director
Isaac P. Ajit, Deputy Director

November 20, 2012

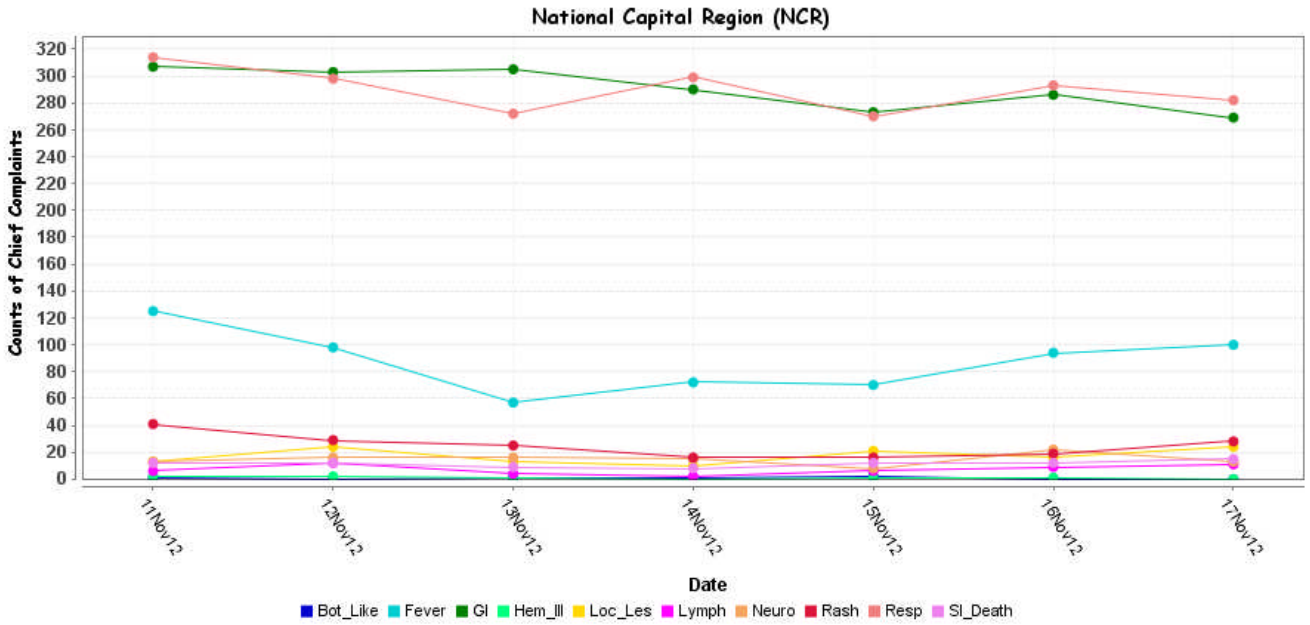
Public Health & Emergency Preparedness Bulletin: # 2012:46
Reporting for the week ending 11/17/12 (MMWR Week #46)

CURRENT HOMELAND SECURITY THREAT LEVELS

National: **No Active Alerts**
Maryland: **Level One (MEMA status)**

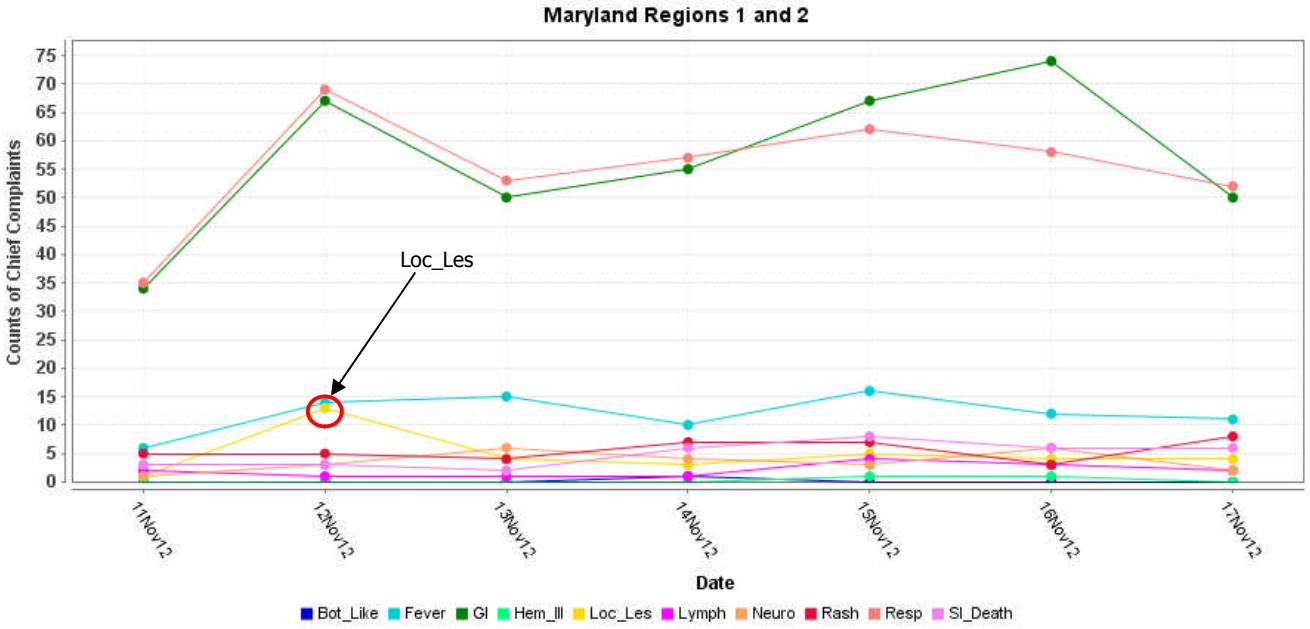
SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

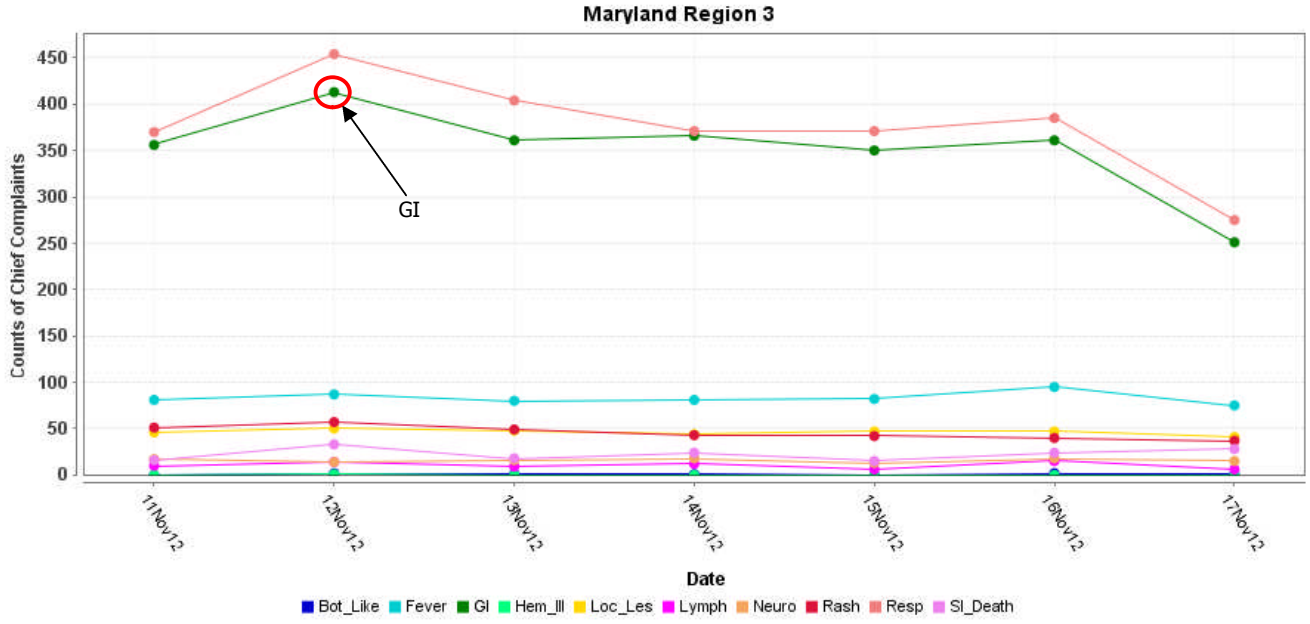


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

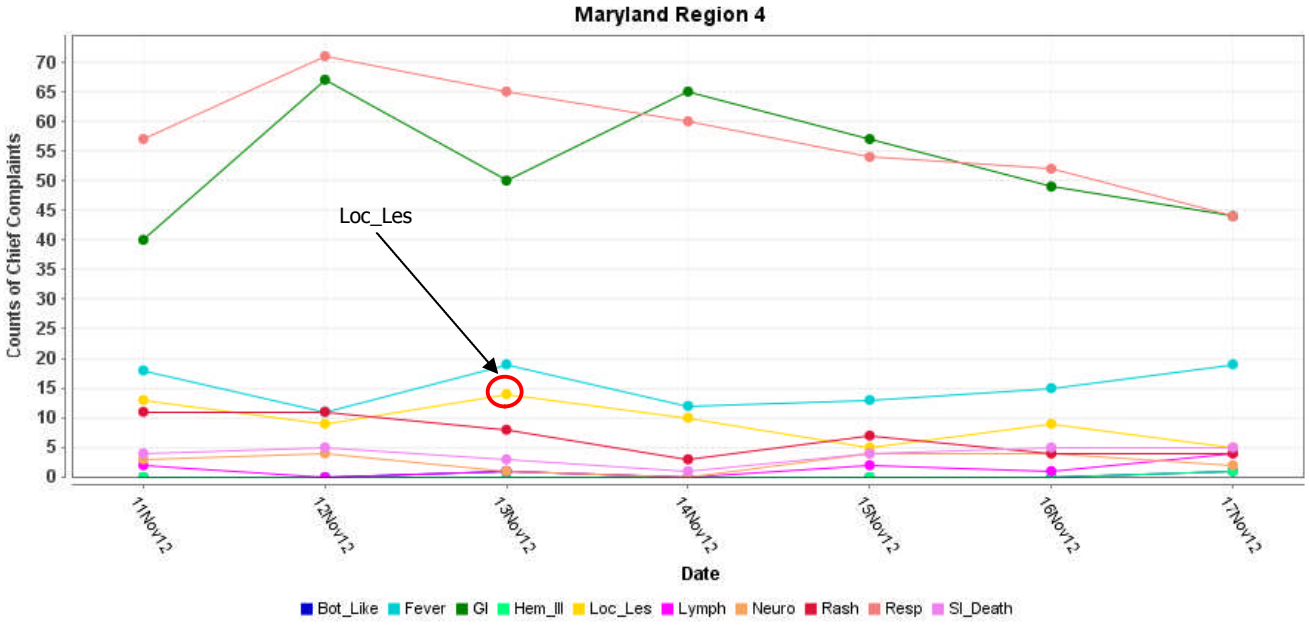
MARYLAND ESSENCE:



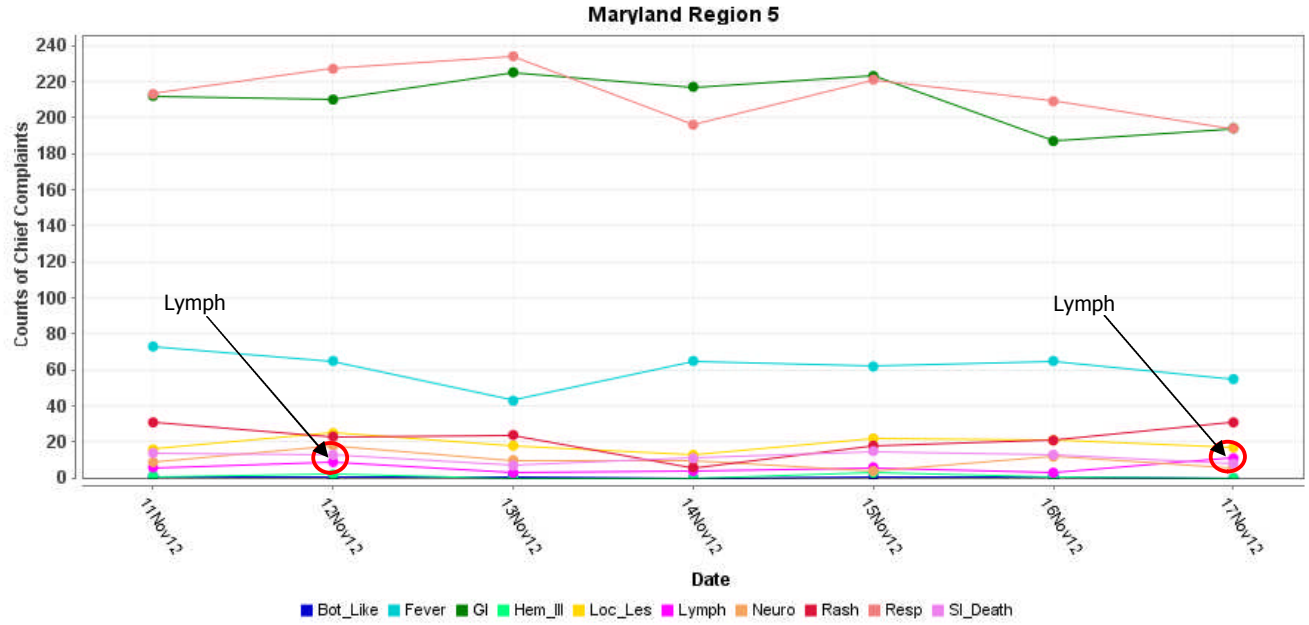
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



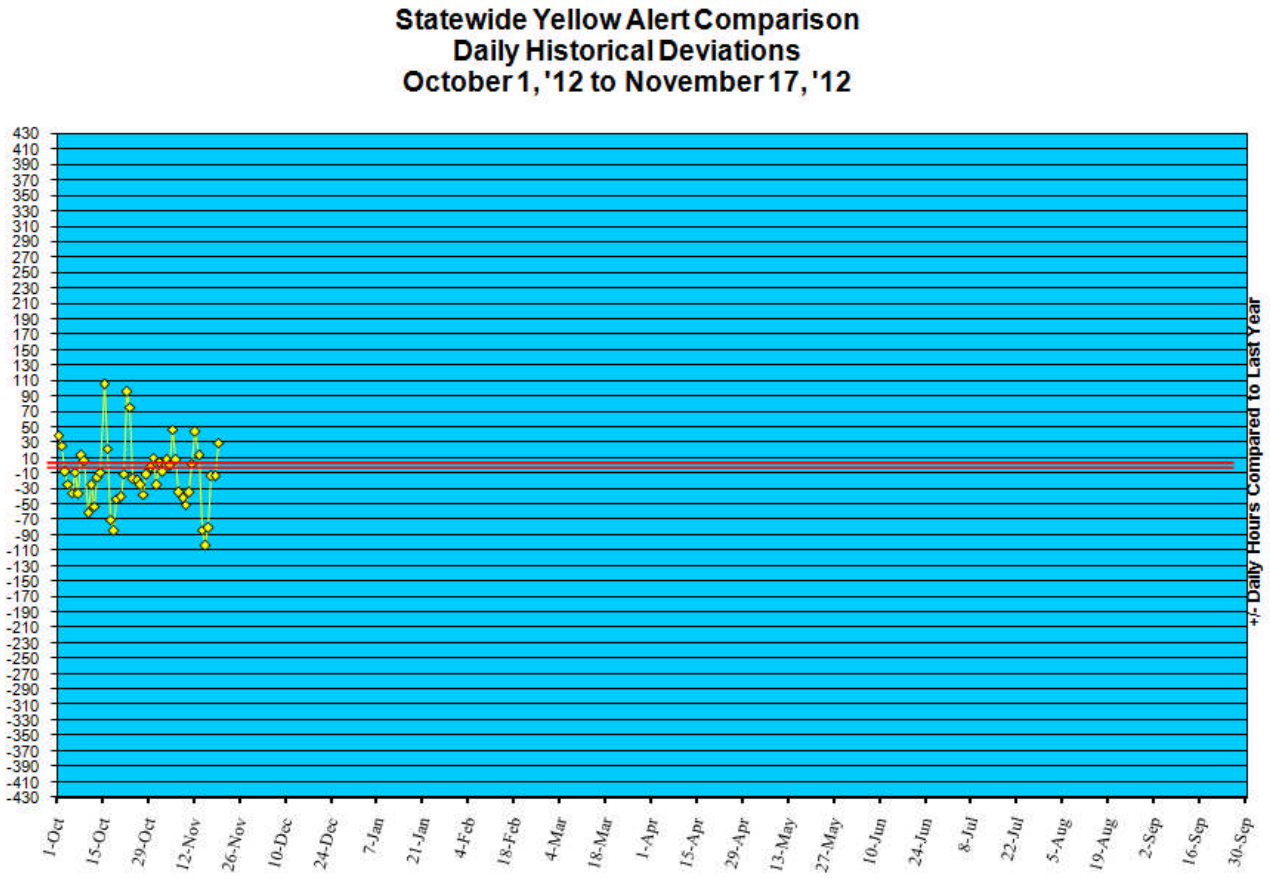
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in October 2012 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (November 11 – November 17, 2012):	13	0
Prior week (November 4 – November 10, 2012):	16	0
Week#46, 2011 (November 13 – November 19, 2011):	17	0

4 outbreaks were reported to DHMH during MMWR Week 46 (November 11-17, 2012)

1 Gastroenteritis outbreak
1 outbreak of GASTROENTERITIS in a Nursing Home

1 Foodborne outbreak
1 outbreak of GASTROENTERITIS/FOODBORNE associated with a Restaurant

2 Respiratory illness outbreaks
1 outbreak of INFLUENZA in a Nursing Home
1 outbreak of ILI/PNEUMONIA in a Nursing Home

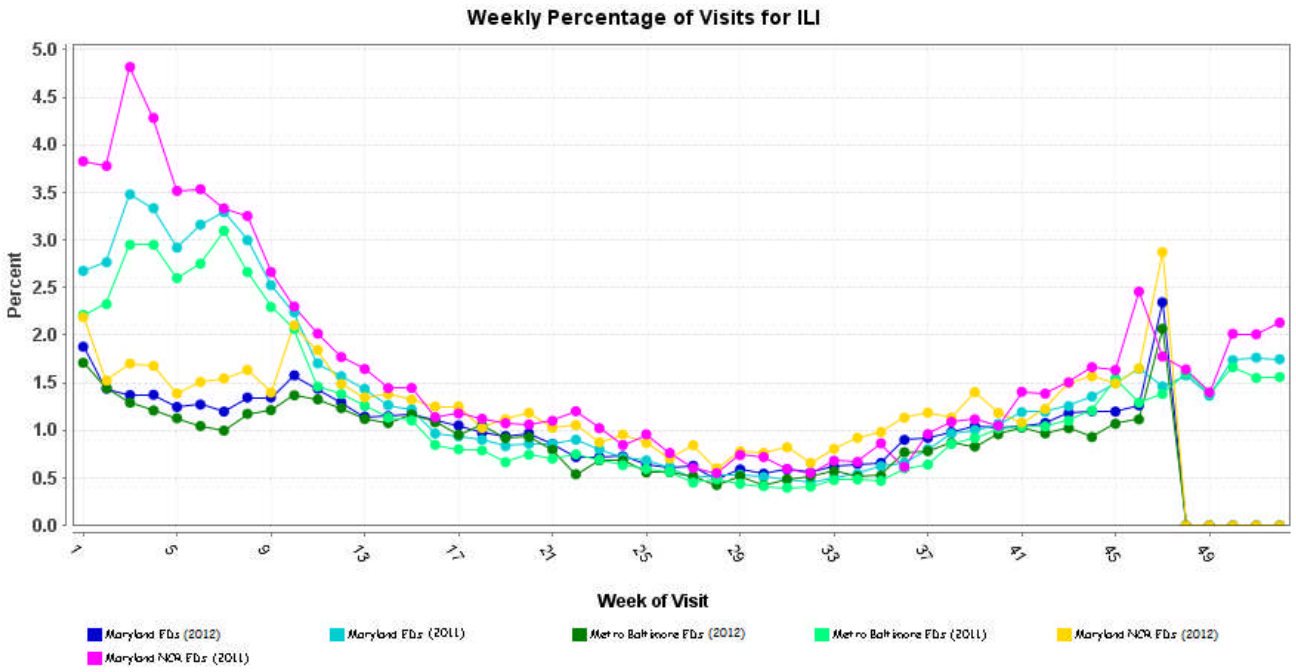
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 46 was: Sporadic Activity with Minimal Intensity.

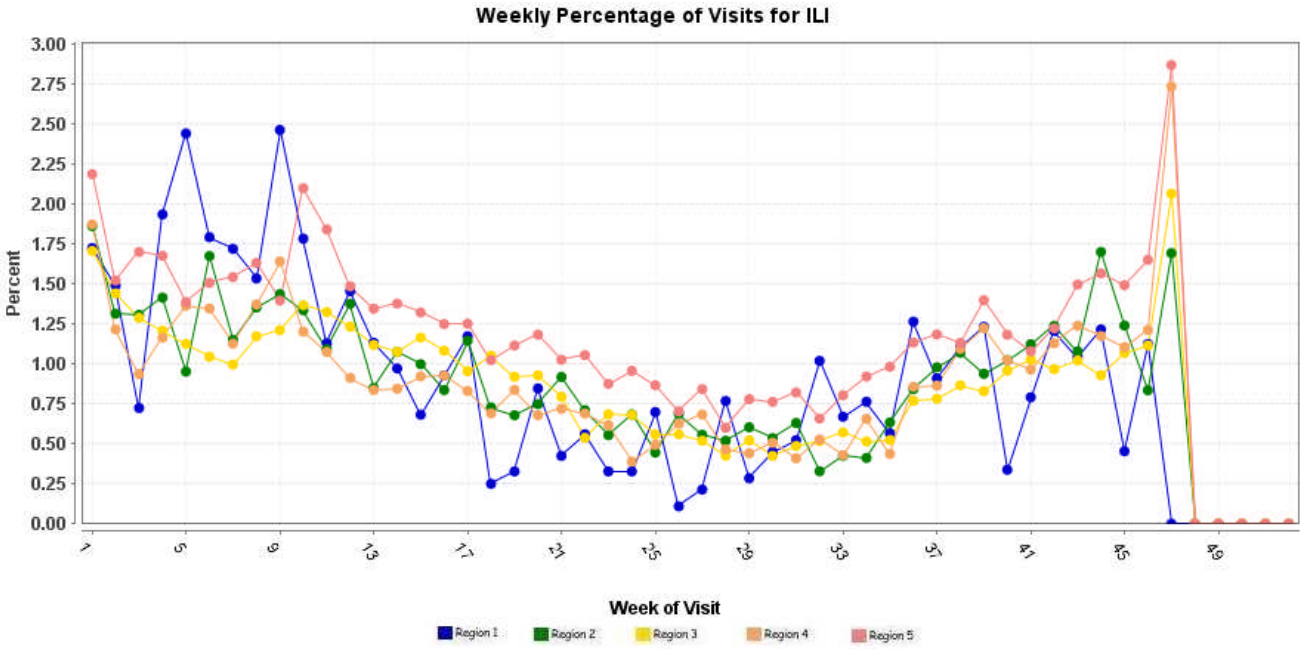
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



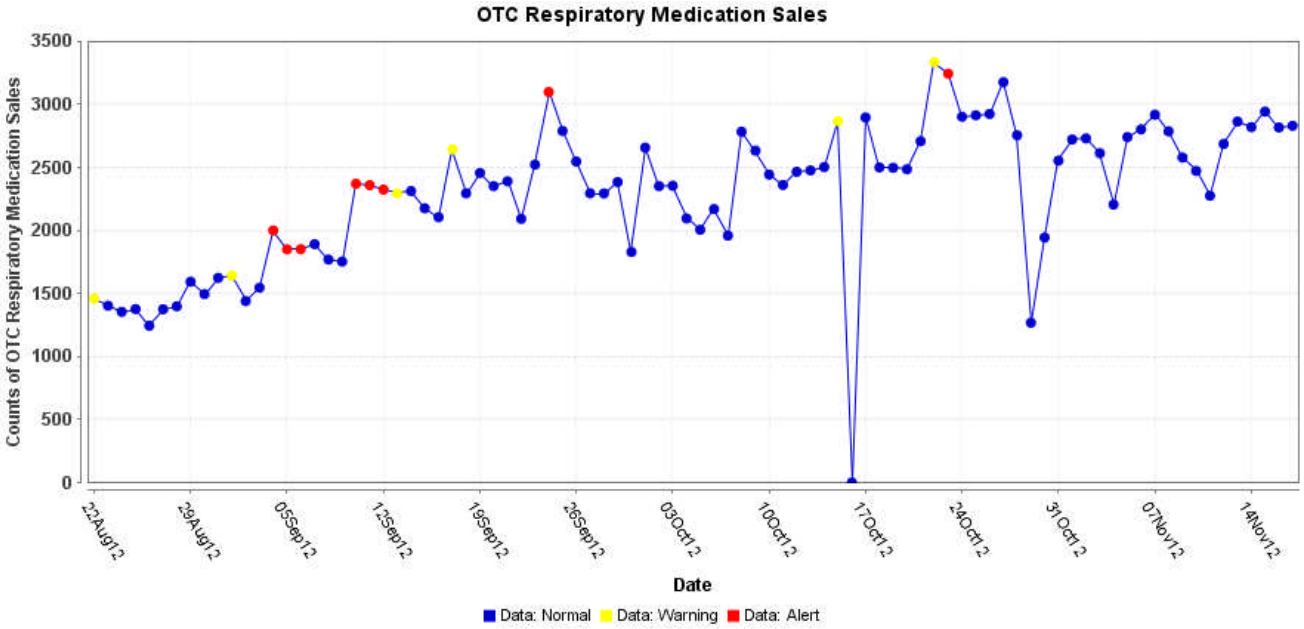
* Includes 2011 and 2012 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2012 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is 3. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic. As of August 10, 2012, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 608, of which 359 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

NATIONAL DISEASE REPORTS*

There were no national disease reports for MMWR Week 46.

INTERNATIONAL DISEASE REPORTS*

YELLOW FEVER (SUDAN): 16 November 2012, Issa Mohamed Musa Yusuf, the minister of health from Central Darfur, told Radio Dabanga that 72 people had died of yellow fever [YF] in the state by Friday [16 Nov 2012]. He also said that 296 people have been infected so far. The minister also told Radio Dabanga that one person died on Thursday [15 Nov 2012] afternoon at a Zalingei hospital as a result of the disease. In addition, he continued, one person from Bindissi locality and another 3 from Um Dukhun locality were recently infected with yellow fever. Cases have also been reported in Jebel Ahmer, Zalingei locality, he said. Yusuf said yellow fever infections are mostly found in the countryside of Central Darfur, adding that this is the disease's worst epidemic in Darfur. According to a citizen from Bishara El-Tayeb, Central Darfur, 35 people have died in the village since the yellow fever outbreak one month ago. Besides, a total of 6 people were diagnosed with the disease on Friday [16 Nov 2012], he said, explaining the spread of yellow fever cannot be contained. Ahmed Ishaq Yaqoup, health minister of West Darfur, announced that 40 people died, and another 113 were infected as a result of the spread of yellow fever in the state. He asserted that rural areas are mostly affected, citing specifically zones around El-Geneina, Mornei and Habila. The minister also confirmed the incidence of the disease in other localities in West Darfur. Empty syringes arrived at the El-Geneina airport in West Darfur on Friday [16 Nov 2012] according to Minister Yusuf. He told Radio Dabanga he expects the vaccine doses to arrive in the region by the end of the last week of November 2012. During a news conference on Friday [16 Nov 2012] in Khartoum, the undersecretary of the federal Ministry of Health announced that he expects vaccinations against yellow fever to arrive in Sudan on Saturday or Sunday [17-18 Nov 2012]. He said that once in Sudan, the vaccines will be sent to Darfur. Hopefully, he concluded, the vaccination process will begin by the end of the next week [the end of the week of 25 Nov 2012]. The minister appealed to citizens from Central Darfur to immediately [report] yellow fever cases to the nearest medical center and to follow the ministry's preventive instructions. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

EBOLA VIRUS (UGANDA): 15 November 2012, A boda boda cyclist who was admitted to Koboko Health Centre IV with signs of Ebola virus [disease] virus has died. The man, whose identity was not disclosed by the doctor who treated him, was brought in on Monday [12 Nov 2012] and passed away on Tuesday [13 Nov 2012]. [Boda-boda (or bodaboda) is a bicycle taxi, originally in East Africa (from English border-border). The bicycle rider can also be called boda-boda. In Uganda it is often abbreviated as simply Boda. The district health officer, Dr Alfred Driwale, told the Daily Monitor on Tuesday evening [13 Nov 2012] that they were treating a case of Ebola virus disease and it was under investigation. "The patient came with hemorrhagic fever and it is unfortunate that he died. Blood samples have been sent to Entebbe to confirm whether he died of Ebola virus disease of or Marburg virus disease," he said. Dr. Driwale explained that the patient had fever, headache, general body ache, yellowing of the eyes, bleeding from the nose and ears, was vomiting blood, and was in a state of mental confusion. This, he said caused suspicion. "We had to use protective gear when treating and burying him. But people should be calm because the disease is not yet confirmed," he added. The man, from Kuluba Sub-county, was admitted after being unwell for 3 days. Upon admission, he was quarantined. A team from Arua hospital was called in to help. According to the doctors, the man had no recent history of travel to neighboring DRC [Democratic Republic of Congo], South Sudan, or Kampala [the capital of Uganda]. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

FOODBORNE ILLNESS (THAILAND): 12 November 2012, Officials on Koh Lanta believe a sick hawksbill sea turtle was the cause of a mass poisoning that may have contributed to the death of a 61-year-old man and resulted in 43 other villagers being admitted to hospital. "Many people in the Urak Lawoi sea gypsy village on Koh Lanta Yai fell ill with an affliction that produced symptoms similar to hand-foot-mouth disease," Koh Lanta District Chief Suriyan Narongkul told the Phuket Gazette. The villagers were admitted to Koh Lanta Hospital for suffering from sore throat, nausea, and diarrhea, he added. A 44-year-old local villager explained to the Gazette that he found a turtle weighing 30 kilograms caught in a fishing net just offshore. "I brought it home and cut it up to share with 10 families in the village, but immediately after eating it my whole family had sore throats, like we had swallowed sand," he explained. "We all went to see the doctor at the hospital. We felt better after taking some medicine, but everyone still has a sore throat after almost a month," the villager said. His 61-year-old father-in-law suffered more than any other family member. "His symptoms were like mine, but he was also vomiting blood. We took him to Koh Lanta Hospital, but he died last Thursday [8 Nov 2012]," the man said. District Chief Suriyan said he had ordered staff from Koh Lanta Hospital, the District Public Health Office and the Koh Lanta District Fisheries Office to investigate the cause of the mass poisoning. "The villagers are feeling better now and 61-year-old man died in part from coexisting diseases, not necessarily from eating the turtle," he said. "The villagers ate a hawksbill sea turtle, which is a protected species, but they didn't know that," Chief Suriyan explained. "In this case, we believe the turtle ate toxic plankton or toxic jellyfish before it was caught in the net and then taken home and eaten by the villagers," he added. "We told the villagers that the turtle is a protected species," said Chief Suriyan. "If anyone finds a rare sea animal, they can report it to the Koh Lanta District Office," he added. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

*National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail me. If you have information that is pertinent to this notification process, please send it to me to be included in the routine report.

Zachary Faigen, MSPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-6745
Fax: 410-333-5000
Email: Zachary.Faigen@maryland.gov

Anikah H. Salim, MPH, CPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-2074
Fax: 410-333-5000
Email: Anikah.Salim@maryland.gov

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable